

Certificate of Need provisions recognized by the Health and Human Services Finance and Support, for the purposes of rate setting, shall be the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Health and Human Services Regulation and Licensure within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Health and Human Services Regulation and Licensure Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Health and Human Services Regulation and Licensure Division of Hospital and Medical Care Facilities. The added costs incurred prior to the date the late amendment or report is filed will not be recognized retroactively for rate setting.

12-011.06K Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the Department of Health and Human Services. All compensation received by an Administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Nebraska Department of Personnel in the "State of Nebraska Salary Survey".

12-011.06L Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing, Direct Support Services, and Other Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing, Direct Support Services, and Other Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing, Direct Support Services, and Other Support Services components, including the administration cost category. If a facility's actual allowable cost for the three components exceeds this quotient, the excess amount is used to adjust the administration cost category.

12-011.06M Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

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TN# MS-03-09

Supercedes      Approved SEP 14 2004      Effective SEP - 1 2003

TN# MS-01-11

12-011.07 Contracting Determination: Prior to January 1, 2001 facilities could elect to contract with the Department for payment for nursing facility services. Effective January 1, 2001, all facilities that are contracting with the Department shall transition, as their contracting term expires, to rate determination per 471 NAC 12-011.08. The Department determines rates for this methodology under the following guidelines, with the provisions of 471 NAC 12-011.07B3 implemented effective August 1 2003.

12-011.07A General Contracting Provisions:

12-011.07A1 Effective Dates: Beginning August 1, 1998, any facility may request to contract with the Department. A contract may only go into effect on the first day of a month. A contract rate period begins the first day of the month following approval by the Department for a facility to contract, and is in effect for the following twelve months. If it is mandatory that a facility contract, the first contract rate period must begin no later than the first day of the month following the date which a Medicaid eligible resident is admitted to an assisted living bed.

12-011.07A2 Time Periods Covered: The facility's contract with the Department covers services provided: 1) from July 1 through the last day of the month before contracting begins, 2) from the first day of the month that contracting begins through the following twelve months, and 3) for the following three one-year extensions.

12-011.07A3 Termination from Contracting Provision: Unless a facility has received grant money under the Nebraska Health Care Trust Fund for the conversion of beds, it may terminate its contract following forty-five days notice to the Department. When a facility terminates its contract, nursing facility payment rates will be calculated under provisions of 471 NAC 12-011.08. The rates received under contracting will continue as the facility's interim rates. If a facility terminates its contract, it is not eligible to contract again for a period of four years; if a change of ownership occurs, the four year period is waived.

A facility which has received a grant from the Nebraska Health Care Trust Fund for the conversion of beds may not terminate contracting provisions.

12-011.07B Notification: The facility must notify the Department of its desire to contract. Notification shall be postmarked no later than 45 calendar days before the facility's desired first contract rate period.

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TN# MS-03-09

Supercedes

Approved

SEP 14 2004

Effective

SEP - 1 2003

TN# MS-01-11

12-011.07B1 Cost Reporting: A cost report must be maintained for the time period which is the basis for setting contracting rates (see 471 NAC 12-011.07B2a) and is subject to audit. A cost report is not required for the twelve-month extension periods; however, upon request by the Department, the facility must make available revenue and cost information from audited reports for governmental facilities, federal form 990 return for non-profit facilities, and federal tax returns for proprietary facilities.

12-011.07B2 Contract Rates: A nursing facility's case-mix payment rates are determined as follows:

12-011.07B2a Cost Report Used: level of care rates are determined from the most current, desk audited cost report. These are rates which would be effective for each prior June 30 cost report period.

12-011.07B2b The Time Period from July 1 to the Date that Contracting Begins: Retroactive rates for this time period are computed as follows when a facility elects to contract:

rates determined from the applicable cost report are projected forward from the midpoint of that cost report period to the midpoint of July 1 to the date contracting begins using the inflation factor. Adjustments are computed using 1/12 of the factor for each month. Interim rates paid during this period are retroactively adjusted to rates thus determined.

12-011.07B2c The Time Period from the Date that Contracting Begins to the End of the following Twelve Months (the First Contract Rate Period): Prospective rates for this time period are computed as follows:

rates determined from the cost report used are projected forward from the midpoint of that cost report period to the midpoint of the contract year using the inflation factor. Partial year adjustments are computed using 1/12 of the Factor for each month.

12-011.07B2d The Time Periods of the Next Three Twelve-Month Extensions: Prospective Rates for each 12 month extension are computed as follows:

rates from the first contract rate period are updated annually, effective the first day of each period, using the inflation factor.

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TN# MS-03-09

Supersedes      Approved SEP 14 2004      Effective SEP - 1 2003

TN# MS-01-11

12-011.07B2e Audit Adjustments: All contract rates may be adjusted based on a subsequent field audit of the cost report which forms the basis of setting rates (see 471 NAC 12-011.07B2a). Final determination of rates occurs when the field audit is finalized.

12-011.07B3 Phase-out of Contracting Provisions: The terms of all contracts existing as of January 1, 2002, will be modified. A contract may expire; a facility under a voluntary contract may notify the Department of its intent to terminate the contractual arrangement; a facility under mandatory contracting provisions may notify the Department of its intent to terminate the contractual arrangement; or any still existing contract will expire on December 31, 2003.

The rates of all facilities contracting as of December 31, 2003, will be updated for the time period of January 1, 2004 through June 30, 2004, by increasing each of the facility's December 31, 2003 rates by 1%.

Contracting facilities' rates for the time period of July 1, 2004 through June 30, 2005, will be computed under provisions of 471 NAC 12-011.08D through 12-011.08D3, with the exception that the July 1, 2002 through June 30, 2003 Report Period cost reports will be used. A 4% inflation factor will be used to increase the facility's allowable costs (June 30, 2002 Component maximums, increased by 2%, will be used).

In the event of conflict between this Section and Sections 12-011.07A through 12-011.07B2e, provisions of Section 12-011.07B3 shall govern.

12-011.08 Rate Determination: The rate determination provisions of 471 NAC 12-011.08 are in effect beginning September 1, 2003. The Department determines rates for facilities under the following cost-based prospective methodology –

12-011.08A Rate Period: Two Rate Periods are defined: 1) September 1, 2003 through June 30, 2004, and 2) July 1, 2004 through June 30, 2005. Rates paid during these two Rate Periods are determined (see 471 NAC 12-011.08D) from cost reports submitted for the June 30, 2002 Report Period (see 471 NAC 12-011.08B).

12-011.08B Report Period: Each facility shall file a cost report each year for the twelve month reporting period of July 1 through June 30.

12-011.08C Care Classifications: A portion of each individual facility's rate may be based on the urban or non-urban location of the facility.

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TN# MS-03-09

Supersedes      Approved SEP 14 2004      Effective SEP - 1 2003

TN# MS-01-11

12-011.08D Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department determines facility-specific prospective per diem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the July 1, 2001 through June 30, 2002 Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

Component maximums are computed using audited data as of the May 15<sup>th</sup> following the end of the Cost Report Period, and are not revised based on subsequent desk audits or field audits. Only cost reports with a full year's data are used in the computation. Cost reports from providers entering or leaving the NMAP during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of four components:

1. The Direct Nursing Component;
2. The Support Services Component;
3. The Fixed Cost Component; and
4. The Inflation Factor.

The Direct Nursing Component and the Support Services Component are subject to maximum per diem payments based on Median/Maximum computations.

Median: For each Care Classification, the median for the Direct Nursing Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding waived, and/or facilities with partial or initial/final full year cost reports. For each Care Classification, the median for the Support Services Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding hospital based, waived, and/or facilities with partial or initial/final full year cost reports.

The Direct Nursing Component median shall be reduced by 2% for facilities that are waived from the 24-hour nursing requirement in order to take into account those facilities' lowered nursing care costs.

Maximum: The maximum per diem is computed as 125% of the median Direct Nursing Component, and 115% of the median Support Services Component. The Direct Nursing Component maximum shall be reduced by 2% for facilities that are waived from the 24-hour nursing requirement in order to take into account those facilities' lowered nursing care costs.

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TN# MS-03-09

Supercedes

Approved

SEP 14 2004

Effective

SEP - 1 2003

TN# MS-01-11

The Fixed Cost Component is subject to a maximum per diem of \$20.00, excluding personal property and real estate taxes.

The facility's prospective rates are computed as the sum of the facility-specific Direct Nursing, Support Services, and Fixed Cost Components adjusted by the Inflation Factor subject to the rate limitations and component maximums of this system. The Direct Nursing, Support Services, and Fixed Cost components are expressed in per diem amounts. The Inflation Factor is a percentage computation.

12-011.08D1 Direct Nursing Component: This component of the prospective rate is computed by dividing the allowable costs for nursing salaries (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Rate determination for the Direct Nursing Component for an individual facility is computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.08D2 Support Services Component: This component of the prospective rate is computed by dividing the allowable costs for support services (lines 34, 63, 78, 93, 104 through 127, 163, 184, and 185 from the FA 66, Resident Transportation - Medical from the Ancillary Cost Center -lines 211 through 218 from the FA-66, and respiratory therapy from the Ancillary Cost Center - lines 203 through 210, from the FA-66), by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Rate determination for the Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.08D3 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 12-011.06B). Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, or a maximum per diem of \$20.00 excluding personal property and real estate taxes.

12-011.08D4 Inflation Factor: For the Rate Period of September 1, 2003 through June 30, 2004, this component of the prospective rate is computed as a 5% increase to each of the facility's rates as computed from the facility's allowable Direct Nursing and Support Services Components, plus the allowable Fixed Cost Component from the June 30, 2002 Report Period. For the Rate Period of July 1, 2004 through June 30, 2005, this component is computed as an additional 2% increase to Direct Nursing and Support Services Components in effect for the period of July 1, 2003 through June 30, 2004.

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TN# MS-03-09

Supersedes

Approved

SEP 14 2004

Effective

SEP - 1 2003

TN# MS-01-11

12-011.08E Exception Process: An individual facility may request, on an exception basis, the Director of HHS Finance and Support to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 10 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increase(s).

12-011.08F Rate Payment for Levels of Care 35 and 36: Rates as determined for Levels of Care 35 and 36 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. The payment rate for Levels of Care 35 and 36 shall be the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

12-011.08H Initial Rates for New Providers: Providers entering the NMAP as a result of a change of ownership shall receive the rate of the seller for the Direct Nursing, Direct Support Services, Other Support Services, and Inflation Factor Components. The Fixed Cost Component shall be controlled by provisions of 471 NAC 12-011.06E Leased Facilities, 471 NAC 12-011.06G Interest Expense, 471 NAC 12-011.06H Recognition of Fixed Cost Basis, and 471 NAC 12-011.09 Depreciation.

Providers entering the NMAP for a reason other than a change of ownership shall receive rates determined from the average base rate components of all providers of the same Care Classification at the time of entering. Provider shall comply with provisions of 471 NAC 12-011.10, Reporting Requirements and Record Retention.

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TN# MS-03-09

Supercedes

Approved SEP 14 2004 Effective SEP - 1 2003

TN# MS-01-11

Rates for the September 1, 2003 through June 30, 2004, and the July 1, 2004 through June 30, 2005 Rate Periods, for new providers entering the NMAP after July 1, 2001, shall be determined as follows:

12-011.08H1 Providers Entering the NMAP between July 1, 2001 and June 30, 2002, and Filing a Partial Year Cost Report for the Period Ended June 30, 2002:

1. For the Rate Period from the date of entering the NMAP to August 31, 2003, providers shall receive the rate of the seller for the Direct Nursing, Direct Support Services, Other Support Services, and Inflation Factor Components. The Fixed Cost Component shall be controlled by provisions of 471 NAC 12-011.06E Leased Facilities, 471 NAC 12-011.06G Interest Expense, 471 NAC 12-011.06H Recognition of Fixed Cost Bases, and 471 NAC 12-011.09 Depreciation and 471 NAC 12-011.08D3 Fixed Cost Component.
2. For the Rate Period of September 1, 2003 through June 30, 2004, providers shall receive rates determined from the average base rate components effective September 1, 2003, of all providers in the same Care Classification. The provider shall comply with provisions of 471 NAC 12-011.10 Reporting Requirements and Record Retention.
3. For the Rate Period of July 1, 2004 through June 30, 2005, rates shall be determined under the provisions of 471 NAC 12-011.08D through 12-011.08D3, with the exception that the provider's July 1, 2002 through June 30, 2003 Report Period Cost Report will be used. A 4% Inflation Factor shall be used to increase the facility's allowable costs, with June 30, 2002 Component maximums increased by 2% applicable.

12-011.08H2 Providers Entering the NMAP between July 1, 2002 and August 31, 2003, and Filing a Partial Year Cost Report for the Period Ended June 30, 2003:

1. For the Rate Period from the date of entering the NMAP to August 31, 2003, providers shall receive the rate of the seller for the Direct Nursing, Direct Support Services, Other Support Services, and Inflation Factor Components. The Fixed Cost Component shall be controlled by provisions of 471 NAC 12-011.06E Leased Facilities, 471 NAC 12-011.06G Interest Expense, 471 NAC 12-011.06H Recognition of Fixed Cost Bases, and 471 NAC 12-011.09 Depreciation and 471 NAC 12-011.08D3 Fixed Cost Component.

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TN# MS-03-09

Supercedes

Approved SEP 14 2004

Effective SEP - 1 2003

TN# MS-01-11

2. For the Rate Period of September 1, 2003 through June 30, 2004, providers shall receive rates determined from the average base rate components effective September 1, 2003, of all providers in the same Care Classification. The provider shall comply with provisions of 471 NAC 12-011.10 Reporting Requirements and Record Retention.
3. For the Rate Period of July 1, 2004 through June 30, 2005, rates shall be determined by increasing their Direct Nursing and Support Services Components in effect June 30, 2004 by 2%, plus their Fixed Cost Component in effect June 30, 2004.

12-011.08H3 Providers Entering the NMAP between September 1, 2003 and June 30, 2005:

1. For the Rate Period from the date of entering the NMAP to June 30, 2004, providers shall receive rates determined from the average base rate Components effective September 1, 2003, of all providers of the same Care Classification. Providers shall comply with provisions of 471 NAC 12-011.10 Reporting Requirements and Record Retention.
2. For the Rate Period of July 1, 2004 through June 30, 2005, rates shall be computed by increasing their Direct Nursing and support Services Components in effect June 30, 2004 by 2%, plus their Fixed Cost Component in effect June 30, 2004.

12-011.08J Providers Leaving the NMAP: Providers leaving the NMAP as a result of change of ownership or exit from the program shall comply with provisions of 471 NAC 12-011.10, Reporting Requirement and Record Retention.

12-011.08K Special Provisions for Governmental Facilities: City or county-owned facilities are eligible to participate in the following transactions to increase reimbursement. Both transactions are subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles). City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility.

1. City or county-owned facilities with a 40% or more Medicaid mix of inpatient days are eligible to receive the Federal Financial Participation share of allowable costs exceeding the applicable maximums for the Direct Nursing and the Support Services Components. This amount is computed after desk audit and determination of final rates for a Report Period by multiplying the current NMAP Federal Financial Participation percentage by the facility's allowable costs above the respective maximum for the Direct Nursing and the Support Services Components. Verification of the eligibility of the expenditures for FFP is accomplished during the audit process.

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TN# MS-03-09

Supercedes      Approved SEP 14 2004      Effective SEP - 1 2003

TN# MS-01-11

2. City or county-owned facilities may also participate in the proportionate share pool. The proportionate share pool is calculated by comparison of the Nebraska Medicaid care classification of residents (see 471 NAC 12-013 Classification of Residents and Corresponding Weights) to Medicare's RUG III care classifications. Each facility's Medicare rates, adjusted by the wage index published in the Federal Register are compared to equivalent Medicaid rates by resident. When more than one Medicare classification could be applicable to a Medicaid classification, an arithmetic average of the Medicare rates is computed.

The methodology shall adjust for pharmacy, laboratory, radiology, retroactive payment adjustments (including adjustments made under 471 NAC 12-011.08K, item 1), and any other factors necessary to equate Medicaid to Medicare payment methodologies.

The Department shall annually submit to CMS workpapers demonstrating the calculation of the proportionate share pool, and that calculations have not resulted in payments in excess of the amount which could reasonably be paid under Medicare payment principles.

The pool for each Report Period is calculated and distributed on or about October 1 of that Report Period. Each facility's distribution amount is based on its estimated proportionate share of the pool.

The initial proportionate share pool is created beginning January 1, 1998. Because this is the midpoint of the July 1, 1997 through June 30, 1998, Reporting Period, the pool is prorated to one half. The date for the estimated distribution for this initial prorated period will be on or about April 1, 1998.

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TN# MS-03-09

Supersedes      Approved SEP 14 2004      Effective SEP - 1 2003

TN# MS-01-11